Benefit Choice Options

State of Illinois

Department of Central Management Services
Bureau of Benefits

Effective July 1, 2004 - June 30, 2005

Rod R. Blagojevich, Governor
Michael M. Rumman, Director

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The State of Illinois intends that the terms of this plan are legally enforceable and that the plan is maintained for the exclusive benefit of Members. The State reserves the right to change any of the benefits and contributions described in this Benefit Choice Options Booklet. This Booklet is produced annually and is intended to update the Benefits Handbook. If there is a discrepancy between the Benefit Choice Options Booklet, the Benefits Handbook and state or federal law, the law will control.

Important Changes For Fiscal Year 2005

Unless otherwise noted, changes take effect July 1, 2004 for all programs, benefits/levels, copayments and deductibles. Full-time employee contributions remain unchanged.

Members Changing Carriers

- Health plan carrier changes (moving between QCHP and managed care health plan or between managed care health plans) elected during Benefit Choice Options Period 2 will be effective September 1, 2004.

Changes to the Quality Care Health Plan (QCHP)

- Family Cap Deductible is $500/$750/$875.
- Individual Out-of-Network/Out-of-Pocket Maximum is $3,500.
- Pre-Certification Penalty is $800.
- Lab/X-ray Coverage is paid at 90%.
- For prescription drug changes, see page 8.
- No change to the contributions for full-time employee or dependent coverage.

Changes to Managed Care Health Plans

- Outpatient Surgery Copayment of $100 has been implemented.
- Retail Prescription Drug Benefits for all Managed Care Health Plans copayments are as follows: $7 - generic; $14 - formulary; and $28 non-formulary. Members enrolled in HealthLink OAP, Health Alliance Illinois or OSF Winnebago, have additional requirements, see the Mail Order Program section on page 8.
- No change to the contributions for full-time employee or dependent coverage.

Changes to Dental Coverage

- The Managed Care Dental Program has been eliminated effective July 1, 2004.
- The Quality Care Dental Program (QCDP) schedule of benefits has changed. See page 16-18 for details.
- No change to the contributions for full-time employee or dependent coverage.
- You can elect not to participate in the dental plan. To terminate your dental coverage during this Benefit Choice period effective as of September 1, 2004, complete Section D of the Benefit Choice Election Form.

Changes to Life Coverage (see page 13)

- Optional life coverage amounts have increased from 1– 4 times to 1– 8 times the basic coverage.
- Spouse and/or child life coverage amount has increased and contributions doubled.

Flexible Spending Account (FSA) Program (see page 14)

- No changes will be allowed to the Dependent Care Assistance Plan (DCAP) during Benefit Choice Option Period 2.
- For the Medical Care Assistance Plan (MCAP), employees may enroll in the program during Benefit Choice Options Period 2 with an effective date of July 1, 2004 and missed deductions must be made up within two pay periods.
- MCAP participants currently enrolled in the program who wish to increase or decrease their enrolled amount, may do so by completing the MCAP Enrollment/Transaction Form. The effective date of the change is July 1, 2004 and payroll deductions must be adjusted accordingly retroactive to paychecks issued on or after July 1, 2004. Currently enrolled MCAP participants cannot terminate from the program during Benefit Choice Options Period 2.
- A new EZ Reimburse Mastercard Program is coming in October 2004 for MCAP participants.
- Participants enrolled in MCAP and/or DCAP who experience a mid-year qualifying change in status event and want to increase or decrease their enrolled amount, see page 14 for information.

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- Participants enrolled in MCAP and/or DCAP who experience a mid-year qualifying change in status event and want to increase or decrease their enrolled amount, see page 14 for information.

Your Responsibilities

Benefit Choice Options Period 2 is July 26 - August 20, 2004. It is the time to review and/or make changes to your health benefit plan. Benefit Choice is the only time, other than a qualifying change in status, that you can change plans or add/drop dependent coverage (see 2000 Benefits Handbook).

Steps to follow to make a Benefit Choice change:

1. **Read the information in this booklet.** It is your responsibility to know the benefit coverages and limitations. If necessary, obtain additional information on the plan in which you are currently enrolled or in which you are considering enrolling.

2. Make your medical plan choices. Review the features below to help you make the best healthcare choices for you and your family. Enrolled dependents are covered by the same medical plan as the member. Plans differ with respect to:

- Services covered
- Deductibles, copayment levels and out-of-pocket maximums
- Geographic limitations
- Healthcare provider network

You have three (3) types of medical plans to choose from:

Managed Care Plans
- Health Maintenance Organizations (HMO)
- Open Access Plan (OAP)

Indemnity Plan
- Quality Care Health Plan (QCHP)

Managed care plans have geographic and provider limitations. If you are interested in a managed care plan, you should carefully review the information on pages 10 & 12 and the Managed Care Plans in Illinois Counties map on page 11. Network provider directories are available from each plan administrator. The QCHP is available regardless of your place of residence.

Remember: There can be changes in your coverage even if you do not change plans. Specific questions regarding coverage should be directed to each respective plan administrator. Telephone numbers and web addresses are listed on page 19.

3. Complete the Benefit Choice Election Form Period 2 that is located at the end of this booklet. Only complete this form if you want to make a change to your benefits during this Benefit Choice election period. Submit the completed form to your Group Insurance Representative (GIR) any time during the Benefit Choice election period that ends on August 20, 2004.

4. Review the Verification Statement that will be mailed to you from the Department of Central Management Services to confirm your Benefit Choice election changes. This statement will be sent to you after your Benefit Choice election has been processed.

Changes to Your Benefit Elections During the Year.

You may change your benefit elections during the year only if you have a qualifying change in status (life event change) that impacts your benefit needs. You must contact your GIR when one of the following events occur:

- You and/or your dependents have a change of address.
- You experience a life event change that may affect eligibility for you or your dependent(s) such as:
  - birth/adoption of a child, (enrollment for a newborn is not automatic. Contact your GIR within 60 days of birth for coverage to be retroactive to birth),
  - marriage, divorce, legal separation or annulment,
  - death of spouse or dependent,
  - employment status change for you, your spouse or your dependent(s) that affects eligibility under the plan,
  - dependent(s) loss of eligibility,
  - court order resulting in the gain or loss of a dependent,
  - change in Public Aid recipient status, or
  - dependent becomes covered by other group health or dental coverage.
- You or your enrolled dependents have other group insurance coverage including Medicare, or gain other coverage during the plan year. Provide a copy of the insurance or Medicare card to your GIR as soon as possible.

The State offers its Members valuable programs...

Flexible Spending Account (FSA) Program

Medical Care Assistance Plan (MCAP) and Dependent Care Assistance Plan (DCAP)

Enrolling in the FSA Program can save you tax dollars for out-of-pocket medical/dental and dependent care expenses incurred during the plan year. FSA allows you to set aside up to $5,000 in each plan for a combined maximum of $10,000 (certain limitations may apply). Join the FSA Program today and start saving! See page 14 for details.

Qualified Transportation Benefit (QTB) Program

The QTB Program can save you money on your eligible commuting and parking expenses. Contributions are conveniently payroll deducted. Transit passes are mailed directly to your home and parking providers can be paid directly. See page 14 for more information.

Deferred Compensation Program

The Deferred Compensation Program is one way to save for the future while enjoying tax savings today. The Program provides an investment opportunity for employees by offering a wide variety of investment options, flexibility to make investment choices and changes conveniently. Contact the Deferred Compensation Program for more information. See page 19 for contacting the Plan Administrator.

Life Insurance Program

Basic term life insurance coverage is provided at no cost to members. Optional life insurance coverage is also available at group rates to members at their own expense. Minnesota Life Insurance Company is the Life Insurance Plan Administrator. See page 6 for contribution information. See page 19 for Plan Administrator information.

Vision Care Benefit Plan

Annual eye examinations are an important part of your overall health, protecting your visual wellness as well as providing early detection of serious health conditions. **The vision plan provides coverage for an annual exam, as well as lenses and frame (or contact lenses) every 24 months.** Contact VSP for more information, see page 19.

Long-Term Care (LTC) Insurance

LTC Insurance can help pay expenses not covered by your health plan or disability insurance. MetLife is the LTC Plan Administrator. Contact MetLife for more information. See page 19 for Plan Administrator information.

Smoking Cessation Program

Members and dependents are eligible to receive a rebate towards the cost of an approved Smoking Cessation Program. The maximum rebate is $200 and is limited to one rebate per year. See your Benefits Handbook for details.

Adoption Benefit Program

Employees working full-time or not less than half-time are eligible for reimbursement of eligible adoption expenses. The adoption must be final before expenses are eligible for this benefit. See your Benefits Handbook for details.

COBRA

Established under provisions of the federal Consolidated Omnibus Budget Reconciliation Act (COBRA), eligible employees, their spouses and dependent children enrolled in a CMS-administered group health plan may purchase continued health and dental coverage if their state group health coverage terminates for specific reasons called “qualifying events”. For detailed information regarding COBRA, see your Benefits Handbook or contact the COBRA Administration Unit. See page 19 for Plan Administrator information.

Employee Assistance Program (EAP)

The Employee Assistance Program provides a valuable resource for support and information during difficult times. See page 9 for further information.

Frequently Asked Questions (FAQs)

Q. If I made changes during Benefit Choice Options Period 1, do I need to complete another form in Benefit Choice Options Period 2?

A. Only complete a form during Benefit Choice Options Period 2 if you want to make another change.

Q. When are the benefit changes (for example, items such as co-payments/co-insurance, etc.) effective?

A. Benefit changes are effective July 1, 2004.

Q. I want to change health plans (for example, move between QCHP and a managed care health plan or between managed care health plans) during Benefit Choice Options Period 2. What is the effective date of my health plan change?

A. The effective date of your plan change will be September 1, 2004.

Q. I am switching from the QCHP to a Managed Care Plan during Benefit Choice Options Period 2. How will claims incurred from July 1 – August 31, 2004 be processed?

A. Claims will be processed through the plan you are enrolled in at the time services were rendered.

Q. I enrolled in MCAP during the first Benefit Choice Options period. What are my options for Benefit Choice Options Period 2?

A. If already enrolled, you can increase or decrease (to the greater of the Program minimum of $20 per month or the amount you have been reimbursed from your FY 05 MCAP account) your MCAP deduction. However, you cannot terminate your participation in MCAP. To increase or decrease your deduction amount, complete the MCAP Enrollment/Transaction Form and submit it to your employing agency Group Insurance Representative (GIR) before August 20, 2004. All MCAP changes elected during Benefit Choice Options Period 2 must be made retroactive to July 1, 2004 and deduction adjustments made within two pay periods.

Q. If I didn't enroll in MCAP during the first Benefit Choice Options Period, can I enroll during Benefit Choice Options Period 2?

A. Yes. In fact, other than when you experience a qualifying change in status, Benefit Choice time period is the only time of year you can enroll in MCAP. Unless you experience a qualifying change in status, this is your last opportunity to enroll in MCAP for FY05.
Also coming later this fiscal year, MCAP is introducing the EZ Reimburse Mastercard Program making participation virtually paperless, so enroll in MCAP today so you can take advantage of this new Program when it becomes available.

Q. Can I enroll in the Dependent Care Assistance Program (DCAP) during Benefit Choice Options Period 2 or change my deduction amount if I'm already enrolled in the Program?

A. No, you cannot enroll or change (increase or decrease) a DCAP account during Benefit Choice Options Period 2 since none of the medical plan changes qualify as a DCAP change in status.

Q. If I am covered by the QCHP, Health Alliance Illinois, HealthLink OAP or OSF Winnebago, I understand if I don't begin purchasing "maintenance" medications through Caremark's Mail Service Program, I will incur a double copayment. Can you provide me a list of medications that Caremark considers "maintenance"?

A. Since the same medication can be prescribed for multiple reasons, there is not a list of maintenance medications available for distribution. Caremark, however, can advise you if any of the medications you or your family members are taking are considered maintenance medications. Call Caremark at (866) 212-4751 for information.

Q. What will happen if I don't use Caremark's Mail Service Program for maintenance medications?

A. Beginning, July 1, 2004 you will be allowed to purchase no more than two 30-day supplies of a maintenance medication. After two fills at the retail level, your copayment amount will double for maintenance medication.

Q. How do I order medications through Caremark's Mail Service Program?

A. To order, obtain an original 90-day written prescription plus up to three (3) 90-day refills from your doctor and complete a Mail Order Service Form (at www.benefitschoice.il.gov). Send the original prescription(s), the completed Mail Order Service Form and the appropriate copayment(s) to Caremark at the address listed on the Form. Allow three weeks for delivery of your prescription although you should receive it within 14 days from the time Caremark receives your order. Photocopies and/or faxes of the prescription are not accepted by Caremark. Therefore, we recommend Members act immediately to obtain an original prescription from your doctor.

Q. How do I order refills through Caremark's Mail Service Program?

A. You will receive a refill form from Caremark with each mail order prescription. For quicker processing, you can also order refills via the Internet or by telephone. Visit Caremark's website at www.caremark.com or call (866) 212-4751 for information.

Q. Is Statement of Health approval (evidence of insurability) required in order for me to increase my optional life coverage?

A. Yes. Medical underwriting is the process used to determine an applicant's insurability under the life plan. Evidence of insurability is required any time you either increase member optional life coverage or add spouse or child life coverage.

Q. If I currently have spouse and/or child life coverage, will I be required to submit a statement of health for the increase to $10,000 coverage?

A. No.

Q. Can I get $5,000 spouse and child life coverage instead of $10,000?

A. No, the only amount of spouse and child life coverage available is $10,000. If you wish to drop spouse and/or child life coverage, you may do so by completing Section F of the Benefit Choice Election Form, or at any other time by contacting your employing agency GIR.

Q. If I do not want spouse and/or child life coverage any longer, will I receive a refund for any contribution that was deducted?

A. Yes, if you cancel during Benefit Choice Period 2, cancellation of coverage will result in a retroactive termination to July 1, 2004 and a refund will be provided.

Q. If I increase my optional coverage to 8 times during Benefit Choice Options Period 2, can I reduce it or drop it at a later date?

A. You may drop, decrease, add or increase optional life coverage in the following situations:

1. **When a Qualifying Change in Status occurs,**
2. **During the annual Benefit Choice Period**
3. **Anytime during the plan year if your current basic life and optional coverage is equal to, or greater than, $50,000. However, if you drop or decrease optional life coverage, the combined optional and basic life coverage must not decrease to an amount less than $50,000.**

Q. What happened to the Managed Care Dental Plan?

A. The Managed Care Dental Plan is no longer offered after June 30, 2004 as an adequate network of dentists could not be maintained. If you were covered by the Managed Care Dental Plan you were automatically enrolled in Quality Care Dental Plan (QCDP) as of July 1, 2004 at the applicable contribution amount.

Q. What if I don't want to pay for dental coverage in the QCDP?

A. You can elect not to participate in the QCDP by completing Section D of the Benefit Choice Election Form Period 2. For dental coverage terminated during Benefit Choice Options Election Period 2, the effective date of the change is September 1, 2004. Declining participation in the dental plan does not affect your coverage under the medical plan.

Q. If I elect to not participate in only the dental plan, can I rejoin the plan at a later date?

A. Yes, but only during future Benefit Choice Periods.

Q. If I'm currently enrolled or considering enrollment in QCHP, what are the plan year deductibles?

A. The table below is the plan year deductibles for the QCHP:

Employee's Annual Salary (Based on each employee's annual salary as of April 1st)	Member Plan Year Deductible	Family Plan Year Deductible Cap
$54,800 or less	$200	$500
$54,801 - $68,600	$300	$750
$68,601 and above	$350	$875
Retiree/Annuitant/Survivor	$200	$300
Dependents	$200	NA

Employee Monthly Health and Optional Life Contributions

Employee Health Contributions: While the state covers most of the cost of employee health coverage, employees also make monthly salary-based contributions for healthcare coverage. The higher the employee's salary, the higher the contribution. Salary-based contributions remain in effect unless the employee retires, accepts a voluntary salary reduction, or returns to state employment at a different salary (this does not apply to employees returning to work from a leave of absence). Employees who enroll in a managed care plan will pay a lower monthly contribution. Employees who reside in Illinois but do not have managed care accessible should contact the CMS Group Insurance Division. For full-time employees the FY05 contribution levels have not increased from FY04.

Employee Annual Salary	Employee Monthly Health Contributions	
$27,300 & below	Managed Care: $27.00	Quality Care: $36.00
$27,301 - $41,200	Managed Care: $32.00	Quality Care: $41.00
$41,201 - $54,800	Managed Care: $34.50	Quality Care: $43.50
$54,801 - $68,600	Managed Care: $37.00	Quality Care: $46.00
$68,601 & above	Managed Care: $39.50	Quality Care: $48.50

Note: If you became a SERS/SURS annuitant/survivor on or after 1/1/98, or a TRS annuitant/survivor on or after 7/1/98, and have less than 20 years creditable service, you may be required to pay a percentage of the cost for your basic coverage. Call your retirement system for applicable contributions. SERS: (217) 785-7444; SURS: (800) 275-7877; TRS: (800) 877-7876.

Monthly Optional Term Life Contributions

Member by Age	Monthly Rate per $1,000
Under 25	$0.05
Ages 25 - 29	0.06
Ages 30 - 34	0.08
Ages 35 - 39	0.09
Ages 40 - 44	0.10
Ages 45 - 49	0.15
Ages 50 - 54	0.26
Ages 55 - 59	0.48
Ages 60 - 64	0.75
Ages 65 - 69	1.42
Ages 70 - 74	2.54
Ages 75 - 79	3.57
Ages 80 - 84	4.25
Ages 85 - 89	5.25
Ages 90 and above	6.50
Accidental Death & Dismemberment	0.02
Spouse (for $10,000 coverage)	**$6.80**
Dependent Children (for $10,000 coverage)	**$0.52**

Contribution Calculation Worksheet

Employee Monthly Health Contribution: $_____
(see chart above)

Dependent Monthly Health Contribution: $_____
(if insuring Dependents, see page 7)

Monthly Dental Contribution: $_____
(see page 7)

Monthly Optional Term Life Contribution: $_____
(see chart to left)

My Total Monthly Contribution: $_____

NOTE: An interactive Premium Calculation Worksheet is available online at www.benefitschoice.il.gov

Dependent Monthly Health and Dental Contributions

Monthly dependent health contributions are in addition to employee health contributions. Dependents must be enrolled in the same plan as the Member under whom they are enrolled. Medicare dependent contributions apply only if Medicare is PRIMARY for both Parts A and B. If you are actively working, and you or your dependents are enrolled in Medicare, become eligible for Medicare Part A and/or Medicare Part B or have questions regarding whether Medicare is primary payer, contact CMS Medicare COB Unit. See page 19 for Plan Administrator contact information.

Dependent Health Plan Contributions				
Health Plan Name and Code	**One Dependent**	**Two or More Dependents**	**One Medicare A and B Primary Dependent**	**Two or More Medicare A and B Primary Dependents**
Quality Care Health Plan (Code: D3)	$150	$180	$ 96	$157
Health Alliance HMO (Code: AH)	$ 74	$ 113	$ 69	$ 113
Health Alliance Illinois (Code: BS)	$ 83	$125	$ 80	$125
HMO Illinois (Code: BY)	$ 63	$ 96	$ 59	$ 96
OSF Health Plan (Code: CA)	$ 72	$ 110	$ 69	$ 110
OSF Winnebago (Code: CE)	$ 87	$132	$ 84	$132
PersonalCare (Code: AS)	$ 72	$ 110	$ 68	$ 110
Unicare HMO (Code: CC)	$ 62	$ 93	$ 57	$ 93
HealthLink OAP (Code: CF)	$ 85	$129	$ 82	$129

Employees who reside in Illinois who enroll dependents, but are not accessible to managed care providers, should contact CMS Group Insurance Division for contribution amounts. See page 19 for Plan Administrator information.

Dental Contributions				
Dental Plan	**Employee Only**	**Employee + 1 Dependent**	**Employee + 2 or more Dependents**	**Retirees, Annuitants, Survivors and Dependents**
Quality Care	$7.50	$12.50	$15.00	$0

Prescription Drug Plan for Quality Care Health Plan (QCHP), Health Alliance Illinois, HealthLink OAP and OSF Winnebago Managed Care Plans

Caremark is your Prescription Drug Plan Administrator if you are enrolled in the QCHP, Health Alliance Illinois, HealthLink OAP or OSF Winnebago managed care plans. If you are not enrolled in one of the above mentioned health plans, contact your health plan Prescription Benefit Manager for detailed prescription information. The coverage provides both in-network and out-of-network benefits. Most drugs purchased with a prescription from a physician or dentist are covered. No over-the-counter drugs will be covered, even if purchased with a prescription. The Preferred Drug List is available from Caremark and is subject to change at any time during the plan year. **Please review the Preferred Drug List and contact your physician to determine if a change in your prescription is appropriate.** To contact Caremark, see page 20.

Mail Service Program

The Mail Service Program allows you to obtain up to a 90-day supply of medication for two copayments.

– QCHP Copayments (90-day supply):

- Generic $16.00
- Formulary Brand $32.00
- Non-Formulary Brand $64.00

– Health Alliance Illinois, HealthLink OAP and OSF Winnebago Copayments (90-day supply):

- Generic $14.00
- Formulary Brand $28.00
- Non-Formulary Brand $56.00

Mail Service Program Procedures: If after two fills at a retail pharmacy, maintenance medication is not obtained from the mail order pharmacy, the member will incur a higher copayment at the retail pharmacy. Maintenance medication is medication taken for chronic conditions such as high blood pressure and high cholesterol. If the Member is unsure if the medication they are currently taking is categorized as maintenance medication, contact Caremark. The Member may obtain up to 2 fills of a maintenance medication (two 30-day supplies) at the retail pharmacy for the retail copayment (QCHP example: $8 for each 30-day supply of a generic medication). Any additional maintenance prescriptions filled at the retail pharmacy will be covered, but at the mail order copayment (QCHP example: for a generic medication, the copayment will be $16.00 for a 30-day supply). If the generic medication is filled through the Caremark Mail Service Program, the copayment will be $16.00 for a 90-day supply.

The Mail Service Program requires you to obtain an original 90-day written prescription plus up to three (3) 90-day refills from your doctor and you must complete the Mail Order Service Form (available at www.benefitschoice.il.gov or by contacting your agency GIR or Caremark). We recommend Members act immediately to obtain an original prescription from the doctor. You should receive your medication within 14-days from the time Caremark receives your order. For information regarding the Mail Service Program contact Caremark.

In-Network Retail Benefits

The pharmacy network consists of retail pharmacies which accept the copayment amounts. For the most up-to-date information on network pharmacies, contact Caremark.

In-network retail benefits when using the Prescription Drug Identification Card:

– No plan year deductibles; no claim forms to file.

– QCHP Copayments (1 to 30-day supply):

- Generic $ 8.00
- Formulary Brand $16.00
- Non-Formulary Brand $32.00

– Health Alliance Illinois, HealthLink OAP and OSF Winnebago Copayments (1 to 30-day supply):

- Generic $ 7.00
- Formulary Brand $14.00
- Non-Formulary Brand $28.00

– The maximum days supply available at one fill is 60 days. However, the copayments described above will double for any prescription exceeding 30 days. Additionally, the Mail Service Program double copayment will also apply to maintenance medications which means, after the first two prescription fills at a retail pharmacy the copayment (two copayments for a 60-day supply) will double.

– When the pharmacy dispenses a brand drug for any reason, and a generic is available, the plan participant must pay the cost difference between the brand product and the generic product, plus the generic copayment of $7.00/$8.00.

– If only a brand drug is available, the applicable copayment will apply: $14.00/$16.00 or $28.00/$32.00.

– When the price of a prescription is lower than the copayment, the pharmacist will collect the lower amount.

When medication is purchased at an in-network pharmacy without presentation of the Prescription Drug Identification Card, you will be charged the full retail cost of the medication. The claim will be processed as if the prescription was filled at an out-of-network pharmacy (see Out-of-Network Benefits).

Out-of-Network Benefits

Prescription drugs may be purchased at out-of-network pharmacies. Reimbursement will be at the applicable brand or generic **in-network** price minus the appropriate in-network copayment. In most cases, the cost of the prescription drugs will be higher when not using in-network pharmacies. Prescriptions filled by an out-of-network pharmacy will require the completion of a claim form (available from Caremark) and supporting documentation.

Coordination of Benefits

This Plan coordinates with Medicare and other group plans; the appropriate copayment will be applied for each prescription filled.

Exclusions

The Plan reserves the right to exclude or limit coverage of specific prescription drugs or supplies.

Employee Assistance Program (EAP)

The Employee Assistance Program (EAP) provides a valuable resource for support and information during difficult times. The EAP is free, voluntary and a confidential program that provides problem identification, counseling and referral services for employees and their covered dependents. You will be directed to counseling services to assist you with a variety of concerns. All calls and counseling sessions are confidential, except as required by law. No information will be disclosed about you unless your written consent is given. Management consultation is also available when an employee's personal problems are causing a decline in work performance. Critical Incident Stress Management is also available through the EAP.

Active State employees and their eligible dependents covered under the State Employees Group Insurance Act may access this benefit regardless of your choice of health plan. Active employees who have elected not to participate (opt out) in the health, dental and vision coverage may also access this benefit.

What number do I call for services?

- There are two separate Employee Assistance Programs for active employees, the EAP through Magellan Behavioral Health and the Personal Support Program (PSP) through AFSCME Council 31.
- Magellan Behavioral Health - Active employees not represented by the master contract agreement between the State and AFSCME must contact Magellan Behavioral Health by calling 1-866-659-3848. Getting help is easy, convenient and available 24 hours a day, seven days a week. See page 20 for Plan Administrator and website information.
- Personal Support Program - Bargaining unit employees represented by AFSCME Council 31 and covered under the master contract agreement between the State of Illinois and AFSCME must access EAP services through the Personal Support Program by calling 1-800-647-8776.

Health Plan Options

Review the features below to help you make the best healthcare choices for you and your family. Enrolled dependents are covered by the same medical plan as the member. Plans differ with respect to:

- Services covered
- Deductibles, copayment levels and out-of-pocket maximums
- Geographic limitations
- Healthcare provider network

You have three (3) types of medical plans to choose from:

Plan	Type	Features
Health Maintenance Organizations (HMO)	Managed Care	•Selection of primary care physician (PCP) •Referrals to specialists often controlled by PCP •Lower out-of-pocket costs
Open Access Plan (OAP)	Managed Care	•Selection of PCP with self-referral to specialists •Out-of-network physician and hospital access •Slightly higher out-of-pocket costs
Quality Care Health Plan (QCHP)	Indemnity Plan	•Access to any physician •Higher out-of-pocket costs

Managed Care Health Plans

There are 8 managed care plans from which to choose. Plans include HMOs and an OAP. All offer comprehensive benefit coverage.

There are distinct advantages to selecting a managed care health plan – namely, lower out-of-pocket costs and virtually no paperwork. Like any health plan option, managed care has its limitations including geographic availability and limited provider networks. If you are considering a managed care plan, explore and research the various plans available. Benefits are subject to the limitations outlined in each plan's Summary Plan Document. Contact the managed care plan administrator for detailed information concerning the various levels of coverage provided. See page 19 for Plan Administrator information.

Health Maintenance Organizations (HMOs)

HMOs operate on an "in-network" structure. Plan participants select a Primary Care Physician (PCP) from the network of participating providers. In conjunction with the health plan, the PCP directs all healthcare services for the plan participant, including visits to specialists and hospitalizations. When medical services are coordinated through the PCP, the plan participant pays only a predetermined copayment. There are no annual plan deductibles for HMO plans.

Open Access Plan (OAP)

The plan is unique because it offers three benefit levels:

Tier I - HMO level of benefits - often paying 100% after a copayment (using a Tier I network provider).

Tier II - self-referral PPO benefits generally paying at 90%, after you pay a deductible (using a Tier II network provider).

Tier III - open access to out-of-network providers where benefits are generally paid at 80% of the usual and customary charges (after a deductible).

Your benefit level is determined by the provider you choose. The plan provider directory contains separate listings of participating providers in the Tier I and Tier II networks so that you will know in advance the level of benefits you will receive.

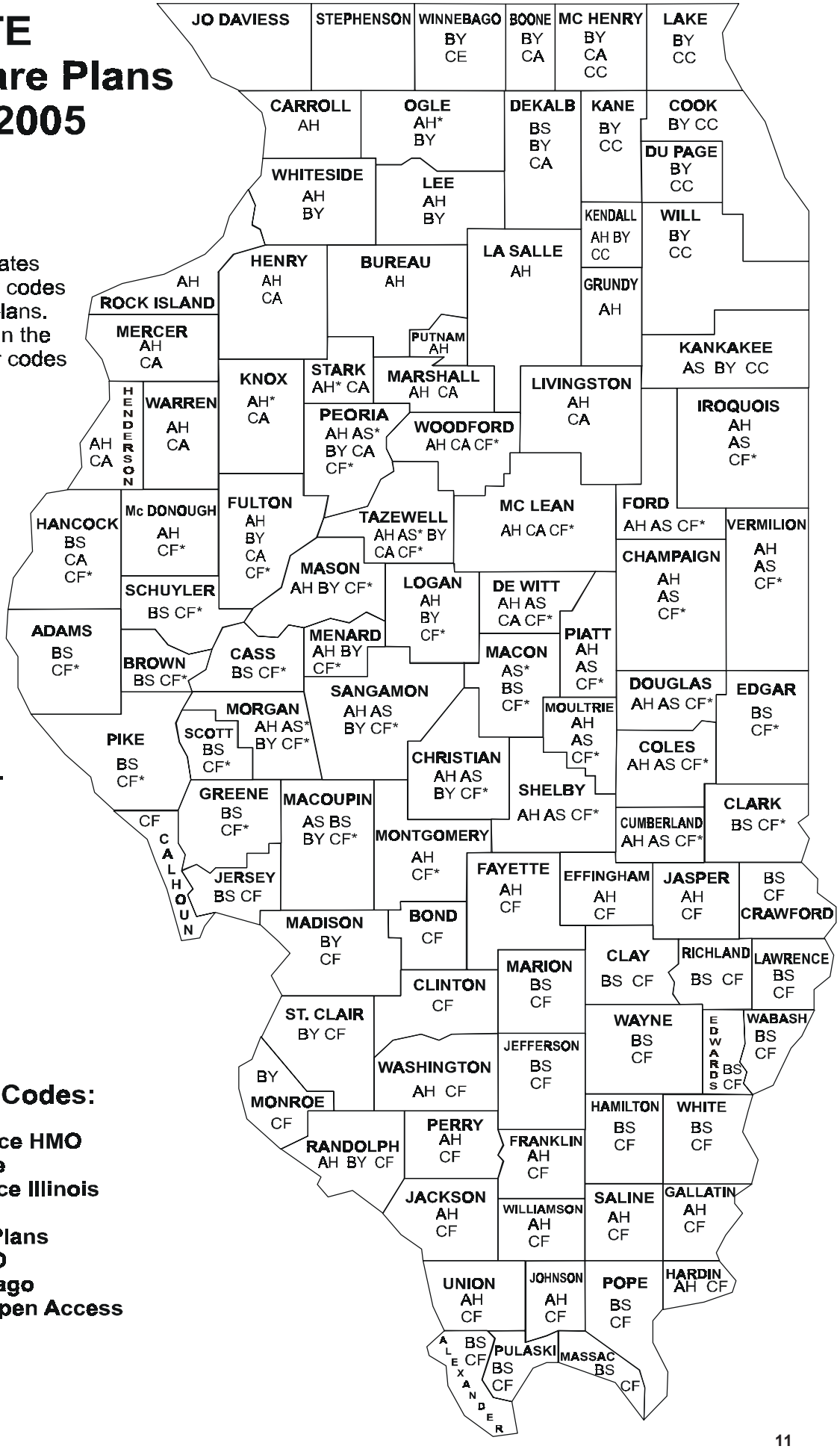
Quality Care Health Plan (QCHP)

QCHP is a medical indemnity plan which offers a comprehensive range of benefits. The QCHP Medical Plan Administrator is CIGNA. Under QCHP, you choose any physician or hospital for general or specialty medical services, and receive higher levels of benefits by using a QCHP Preferred Provider Organization (PPO) hospital or the CIGNA Healthcare PPO Network of providers and facilities. Intracorp is the QCHP Notification Administrator/Medical Case Management Administrator. Magellan Behavioral Health is the QCHP Notification Administrator for mental health/substance abuse services. Notification to Magellan is required for services at all levels of care to avoid penalties or non-authorization of benefits. See page 20 for Plan Administrator information.

STATE Managed Care Plans For FY 2005

The key below indicates the two-letter carrier codes for HMO and OAP plans. Plans are available in the counties where their codes appear.

*** If an asterisk appears by one of the managed care plans, it means the plan is new to that county.**



HMO and OAP Codes:

AH = Health Alliance HMO
AS = PersonalCare
BS = Health Alliance Illinois
BY = HMO Illinois
CA = OSF Health Plans
CC = UniCare HMO
CE = OSF Winnebago
CF = HealthLink Open Access

Medical Plan Comparison

Benefit	QCHP	HMO	OAP Tier I	OAP Tier II	OAP Tier III (Out-of-Network)
Plan Year Maximum Benefit	Unlimited	Unlimited	Unlimited	Unlimited	$1,000,000
Lifetime Maximum Benefit	Unlimited	Unlimited	Unlimited	Unlimited	$1,000,000
Patient Responsibilities					
Annual Out-of-Pocket Maximum • Per Enrollee • Per Family	**General:** $800 per enrollee $2,000 per family/plan year **Non-PPO Hospital:** $3,500 per enrollee $7,000 per family/plan year	$1,500 $3,000	Not Applicable	$600 $1,200	$1,500 $3,500
Other Deductibles/Copayments: **Emergency Room** **Non-PPO/Out-of-Network Hosp.Adm.**	$200 $200	$100 No Coverage	$100 See Tier III for benefit level	$100 + 10% Network Charges See Tier III for benefit level	$100 + 20% Network Charges $300 + 20% of U&C
Annual Plan Deductible *Must be satisfied for all services*	$ 200 - $350 (salary based premium)	$0	$0	$200 Per Enrollee	$300 Per Enrollee
Plan Benefit Levels Comparison*					
Inpatient	90% - PPO 80% or 65% - Non-PPO	$150 copayment	$150 copayment	90% of network charges after $200 copayment	80% of U&C after $300 copayment
Outpatient Surgery	90% for PPO Network Provider	$100 copayment	$100 copayment	90% of network charges after $100 copayment	80% of U&C after $100 copayment
Diagnostic Lab & X-ray	90% of U&C	100%	100%	90% of network charges	80% of U&C
Durable Medical Equipment	80% of U&C	80% of network charges	100%	90% of network charges	80% of U&C
Physician Office Visit	90% PPO 80% of U&C Non-PPO	$10 copayment	$10 copayment	90% of network charges for covered services	80% of U&Cfor covered services
Preventive Services	80% or 100% for specific services	$10 copayment	$10 copayment	90% of network charges for covered services	Covered In-Network only
Examples of Out-of-Pocket Expenses*					
$25,000 Expense **Inpatient Hospitalization**	$800 Maximum PPO Out-of-Pocket	$150 Admission Copayment In-Network	$150 Admission Copayment In-Network	$600 Maximum Out-of-Pocket In-Network	$1,500 Maximum Out-of-Pocket
$25,000 Expense **Inpatient Out-of-Network** **Hospitalization**	$3,500 Maximum Out-of-Pocket	$25,000 No Coverage at an Out-of-Network Hospital	$25,000 No Coverage at an Out-of-Network Hospital	$25,000 No Coverage at an Out-of-Network Hospital	$1,500 Maximum Out-of-Pocket
$15,000 Expense **Outpatient Surgery**	$800 Maximum PPO Out-of-Pocket	$100 Copayment In-Network	$100 Copayment In-Network	$600 Maximum Out-of-Pocket In-Network	$1,500 Maximum Out-of-Pocket
$1,000 Expense **Emergency Room Visit**	$280 ($200 ER Deductible + 10% PPO Coinsurance)	$100 Copayment	$100 Copayment	$190 ($100 Copayment + 10% of Charges)	$280 ($100 Copayment + 20% U&C)

*Note: Benefit Levels are general guidelines and for comparison purposes only. These examples make assumptions and each claim is unique. Contact the plan administrator for specific coverage details. Each example assumes the annual plan deductible has been met. The cost estimates in each example represent the U&C (QCHP & TIER III) and network (HMO & TIERS I & II) charges for facilities only. The examples do not include physician charges.

Life Insurance Coverage

Member Optional:

- Optional life insurance amounts available for active members and eligible annuitants under age 60 have increased from 1– 4 times the basic coverage to 1– 8 times the basic coverage with a maximum of $3,000,000 when combined with basic coverage. Survivors (prior to Sept. 22, 1979) may elect 1– 4 times their basic coverage amount.

- Optional life coverage in excess of 4 times the basic coverage will terminate when an annuitant turns age 60.

- Members may add/drop/increase or decrease optional life coverage during the Benefit Choice Options Period 2 by completing Section E of the Benefit Choice Election Form.

- Evidence of insurability is required for adding or increasing member optional life coverage. A Statement of Health form must be completed and submitted to Minnesota Life Insurance Company. Contact your agency GIR to obtain a Statement of Health form or visit the Benefit Choice website at (www.benefitschoice.il.gov). Increases to optional life coverage are subject to approval by Minnesota Life Insurance Company. For Benefit Choice Options Period 2 the effective date for adding or increasing optional life coverage will be the pay period following the Statement of Health approval date.

- New employees may elect 1– 4 times their basic coverage during the initial enrollment period without evidence of insurability.

Accidental Death and Dismemberment (AD&D):

- The maximum AD&D coverage an employee may elect is 5 times their basic coverage (basic plus 4 times optional coverage).
- Members may add or drop coverage during the Benefit Choice Options Period 2 by completing Section E of the Benefit Choice Election Form.
- Evidence of insurability is not required to obtain AD&D coverage.

Spouse/Child Life:

- If spouse and/or child life coverage is currently in effect, the coverage amount will be automatically increased (without evidence of insurability) from $5,000 to $10,000 and contributions doubled retroactive to July 1, 2004.
- The monthly contribution for spouse coverage will be $6.80 per month and the child life contribution will be $0.52 per month. An employee can elect, during Benefit Choice Options Period 2, to retroactively terminate this coverage to July 1, 2004 and a refund will be issued, if applicable.
- Members may add or drop coverage during the Benefit Choice Options Period 2 by completing Section F of the Benefit Choice Election Form.
- Evidence of insurability is required when adding spouse and/or child life coverage. A Statement of Health form must be completed and submitted to Minnesota Life. Contact your agency GIR to obtain a Statement of Health form or visit the Benefit Choice website at (www.benefitschoice.il.gov). For Benefit Choice Options Period 2 the effective date for adding spouse and/or child life coverage will be the pay period following the Statement of Health approval date.
- Spouse life coverage will reduce to $5,000 when an eligible annuitant turns age 60. However, child life coverage will remain at $10,000 for both active Members and eligible annuitants.

Qualified Transportation Benefit (QTB) Program

The Qualified Transportation Benefit (QTB) Program is an optional benefit that gives eligible employees the opportunity to use tax-free dollars to pay for their out-of-pocket, work-related commuting and/or parking expenses. This lowers your taxable income and increases your spendable income. WageWorks is the Plan Administrator for QTB.

The transportation benefit allows you to use up to $100 per month to pay for transit passes for the bus or train, or for vanpooling expenses incurred for work-related commuting costs. The transit media you select is conveniently mailed directly to your home before the beginning of the month the pass is to be used. The parking benefit allows you to payroll deduct up to $190 per month to pay for work-related parking expenses. You may elect to have your parking provider paid directly or may be reimbursed by submitting a claim form and proof of services or by completing an online claim form.

Full-time and part-time employees working 50% or more and who have payroll checks processed through the Office of the Comptroller may enroll in the Program at any time. There is no qualifying change in status required to enroll mid-year and you may cancel or change your deductions at any time. Your enrollment, change, or cancellation must be made by the 10th day of the month for the benefit to begin the next month. For example, a selection made on or before January 10th would begin in February.

You elect the amount you want deducted from your paycheck upon enrollment into the Program. Your payroll office is notified of the deduction amount you elected. Deductions are made before federal, state and Social Security taxes are withheld. To estimate your savings, visit the WageWorks website at www.wageworks.com and use the Commuter Savings Calculator. To enroll, change, or cancel your election contact WageWorks, see page 19 for Plan Administrator information.

The Flexible Spending Account (FSA) Program

The FSA Program is an optional benefit that allows eligible employees to set aside up to $5,000 tax-free to one or both of the plans for a combined maximum of $10,000. The amount designated is payroll deducted and deposited into the account(s) prior to federal, state and Social Security tax withholdings thereby lowering taxable income, and increasing your spendable income. Fringe Benefit Management Company (FBMC) is the Plan Administrator for the FSA Program. The Plans are as follows:

- **Medical Care Assistance Plan (MCAP)** - allows you to pay eligible out-of-pocket medical and dental expenses incurred during the plan year. For eligibility information contact your GIR or the FSA Unit.

- **Dependent Care Assistance Plan (DCAP)** - allows you to pay eligible child and/or adult day care expenses incurred during the plan year. For eligibility information contact your GIR or the FSA Unit.

MCAP enhancements effective July 1, 2004:

- Over-the-Counter (OTC) medicines/drugs - are now eligible for reimbursement through MCAP. Contact FBMC for details.

- Orthodontia - continues to be an eligible reimbursable expense. However, the proration requirement has changed. Contact FBMC or the FSA Unit for details.

- A new EZ Reimburse Mastercard Program is coming in October 2004 for MCAP participants. This Program makes MCAP participation virtually paperless. The $20 annual EZ Reimburse Mastercard Program fee has been waived for this introductory year. For more information, visit www.fbmc-benefits.com (select Products and Services).

  - If you are enrolling in MCAP during Benefit Choice Options Period 2, and wish to enroll in the EZ Reimburse Mastercard Program, be sure to check the appropriate box on the MCAP Enrollment/Transaction Form.

  - If you're currently enrolled in MCAP and wish to enroll in the EZ Reimburse Mastercard Program, you will receive a form in August 2004 from the FSA Unit ---complete and return the form timely so you don't miss out on participating in this new program for MCAP.

FSA Program change effective July 1, 2004:

- The normal period of coverage for participants enrolling in the Program during Benefit Choice is July 1-June 30 each plan year. For participants enrolled in MCAP and/or DCAP who experience a mid-year qualifying change in status event and subsequently change their FSA deduction amount, your plan year will be divided into two or more periods of coverage (dependent upon the number of qualifying changes in status you experience). Allowable expenses for each period must be incurred during that timeframe and expenses are reimbursed based upon the enrolled amount.

Deferred Compensation Program

The Deferred Compensation Program is a long-term supplemental retirement program that provides State of Illinois employees the opportunity to save for the future by offering tax-savings, a variety of investment options, the flexibility to make investment changes and convenient services.

Benefits from Participation in the Deferred Compensation Program

Combined pension and Social Security benefits may not be sufficient for retirement needs. Deferred Compensation is one way to save for the future while enjoying tax benefits today. Participating in the Plan will not affect Social Security benefits, pension benefits or the ability to save independently.

- **Reduce taxable income**
  The amount contributed to a deferred compensation account reduces taxable income which allows more savings, less taxes and more spendable income.
- **Investment earnings grow tax-free**
  The money contributed and any interest or earnings on contributions grow free of taxes until withdrawal. At that point, only federal taxes are payable. Deferred Compensation distributions are not subject to Illinois State taxes.

Eligibility

All State of Illinois employees, including contractual and temporary employees, are eligible to participate in this Program.

Enrollment

There is no specific enrollment period; state employees may enroll at any time. An enrollment form is available from the Deferred Compensation Division or from the Agency Liaison. You can also access the Plan's web site for comprehensive information and download the necessary forms at www.state.il.us/cms/employee/defcom. The enrollment form must be submitted in the month prior to the month in which deferrals begin. All contributions are through payroll deduction only.

Contribution Limitations

Contribution amounts may be as little as $20 per month up to $13,000 for tax year 2004 and $14,000 for tax year 2005. Participants age 50 and older will be allowed an additional "catch-up" amount for a total contribution of $16,000 for tax year 2004 and $18,000 for tax year 2005.

Investment Choices

There are a variety of funds in which to invest. This makes it easy to customize an investment strategy that is just right for you. Individuals decide how much and where to invest the money deferred. Money may be exchanged between funds once per calendar quarter at no charge. Additional exchanges cost $10 per transaction.

Cost of Participation

The Plan has currently accumulated sufficient reserves to cover the administrative expenses for the 2004 calendar year. Therefore, the 0.15% administrative fee (maximum cap of $45) will not be charged against participant accounts. A review will be conducted to determine administrative fees for the 2005 calendar year.

Distribution

There are specific distribution events:

- Money may be withdrawn at retirement or termination of employment with the State of Illinois regardless of age. At that time, only federal taxes are payable. There are several distribution options from which to choose including lump-sum and installment payouts.
- Money may be withdrawn from the account prior to retirement or termination of employment only in the event of a severe financial hardship.
- Upon death of the plan participant, the account is paid to the named beneficiary(ies).

For More Information

Contact the Deferred Compensation Division or the Agency Liaison for additional information. See page 19 for the Deferred Compensation Plan Administrator.

Quality Care Dental Plan - Schedule of Benefits

Plan Design	Quality Care Dental Plan
Annual Deductible	$50 individual plan deductible for dental services other than those listed as "preventive or diagnostic" on the Schedule of Benefits.
Maximum Benefit Limit	$2,000 per person per plan year after plan deductible.
Maximum Benefit Level for Child Orthodontics (under age 19)	$1,500 lifetime maximum depending on length of treatment after plan deductible. Orthodontic benefits count toward maximum annual benefits above.

Diagnostic Services	Maximum Benefit	Code
Periodic Oral Examination	$ 28	D0120
Limited Oral Evaluation (specific oral health problem)	$ 47	D0140
Comprehensive Oral Examination	$ 49	D0150
Radiographs/Diagnostic Imaging		
Intraoral Complete Series (once in a period of three plan years, including bitewings)	$ 87	D0210
Intraoral - Periapical First Film	$ 17	D0220
Intraoral - Periapical Each Additional Film	$ 13	D0230
Bitewing Single Film	$ 18	D0270
Bitewing Two Films	$ 28	D0272
Bitewing Four Films	$ 39	D0274
Panoramic Film, (once in a period of three plan years)	$ 80	D0330
Preventive Services	**Maximum Benefit**	**Code**
Prophylaxis Adult - Twice each plan year	$ 60	D1110
Prophylaxis Child - Twice each plan year	$ 41	D1120
Topical Application of Fluoride - Child **(includin**g prophylaxis) (once each plan year, covered through age 18 only)	$ 65	D1201
Topical Application of Fluoride - Child **(not including** prophylaxis) (once each plan year, covered through age 18 only)	$ 26	D1203
Sealant - per tooth, covered through age 18 only	$ 36	D1351
Space Maintainers (Passive Appliances)		
Fixed Unilateral	$232	D1510
Fixed Bilateral	$306	D1515
Removable Unilateral	$288	D1520
Removable Bilateral	$395	D1525
Restorative Services	**Maximum Benefit**	**Code**
Amalgam Restorations		
Amalgam One Surface, Primary or Permanent	$ 75	D2140
Amalgam Two Surfaces, Primary or Permanent	$ 97	D2150
Amalgam Three Surfaces, Primary or Permanent	$118	D2160
Amalgam Four or more Surfaces, Primary or Permanent	$143	D2161
Resin-Based Composite Restorations		
One Surface, Anterior	$ 90	D2330
Two Surfaces, Anterior	$ 115	D2331
Three Surfaces, Anterior	$ 141	D2332
Four or more Surfaces or involving incisal angle (anterior)	$167	D2335
One Surface Posterior	$106	D2391
Two Surface Posterior	$138	D2392
Three Surface Posterior	$172	D2393
Four or More Surfaces, Posterior	$210	D2394
Crowns/Single Restorations Only		
Crown-Resin (laboratory)	$213	D2710
Crown-Resin with high noble metal	$525	D2720
Crown-Resin predominantly base metal	$492	D2721
Crown-Resin with noble metal	$503	D2722
Crown-Porcelain/Ceramic Substrate	$539	D2740
Crown-Porcelain fused to high noble metal	$532	D2750
Crown-Porcelain fused to predominantly base metal	$495	D2751
Crown-Porcelain fused to noble metal	$507	D2752
Crown-3/4 cast predominately base metal	$480	D2781
Crown-Full cast high noble metal	$513	D2790
Crown-Full cast predominantly base metal	$486	D2791
Crown-Full cast noble metal	$495	D2792
Other Restorative Services		
Recement Inlay	$ 49	D2910
Recement Crown	$ 51	D2920
Prefabricated stainless steel Crown (primary tooth)	$140	D2930
Prefabricated stainless steel Crown (permanent tooth)	$158	D2931
Prefabricated Resin Crown	$172	D2932
Endodontics	**Maximum Benefit**	**Code**
Pulp Capping		
Pulp Cap - Direct (excluding final restoration)	$ 41	D3110
Pulp Cap - Indirect (excluding final restoration)	$ 32	D3120
Pulpotomy - Therapeutic (excluding final restoration)	$ 97	D3220
Root Canal Therapy (include intra-operative radiographs)		
Anterior (excludes final restoration)	$412	D3310

Quality Care Dental Plan - Schedule of Benefits

Bicuspid (excludes final restoration)	$503	D3320
Molar (excludes final restoration)	$649	D3330
Retreatment of Previous Root Canal Therapy		
Anterior	$554	D3346
Bicuspid	$653	D3347
Molar	$785	D3348
Periodontics	**Maximum Benefit**	**Code**
Gingivectomy/Gingivoplasty		
Per quadrant	$238	D4210
Per tooth	$102	D4211
Gingival Flap Procedure		
Per quadrant - includes root planning	$280	D4240
Gingival Flap - including root planning, 1-3 teeth per quadrant	$145	D4241
Osseous Surgery (including flap entry and closure)		
Per quadrant	$453	D4260
Bone Replacement Graft		
First site in quadrant	$137	D4263
Each additional site in quadrant	$ 68	D4264
Pedicle Soft Tissue Graft	$335	D4270
Free Soft Tissue Graft	$344	D4271
Provisional Splinting		
Intracoronal	$168	D4320
Extracoronal	$147	D4321
Periodontal Scaling and Root Planing		
Per quadrant	$ 91	D4341
Full Mouth Debridement to Enable Comprehensive Periodontal Evaluation and Diagnosis	$ 61	D4355
Periodontal Maintenance Procedure		
Following active therapy	$ 55	D4910
Unscheduled Dressing Change	$ 47	D4920
Prosthodontics	**Maximum Benefit**	**Code**
Removable Prosthetics		
Complete Denture - Maxillary	$543	D5110
Complete Denture - Mandibular	$543	D5120
Immediate Denture - Maxillary	$592	D5130
Immediate Denture - Mandibular	$592	D5140
Partial Dentures (removable)		
Maxillary Partial Denture - resin base (conventional clasps, rests and teeth)	$458	D5211
Mandibular Partial Denture - resin base (conventional clasps, rests and teeth)	$533	D5212
Maxillary Partial Denture - cast metal framework, resin base (conventional clasps, rests and teeth)	$600	D5213
Mandibular Partial Denture - cast metal framework, resin base (convention clasps, rests an teeth)	$600	D5214
Unilateral, Partial Denture, Removable - one piece cast metal (includes clasps and teeth)	$350	D5281
Adjustments to Dentures		
Adjust complete denture - Maxillary	$ 30	D5410
Adjust complete denture - Mandibular	$ 30	D5411
Adjust partial denture - Maxillary	$ 30	D5421
Adjust partial denture - Mandibular	$ 30	D5422
Repairs to Complete Dentures		
Repair broken complete denture base	$ 59	D5510
Replace missing or broken teeth - complete denture (each tooth)	$ 50	D5520
Repairs to Partial Dentures		
Repair resin denture base	$ 64	D5610
Repair cast framework	$ 69	D5620
Repair or replace broken clasp	$ 84	D5630
Replace broken teeth - per tooth	$ 55	D5640
Add tooth to existing partial denture	$ 74	D5650
Add clasp to existing partial denture	$ 89	D5660
Denture Rebase Procedure		
Rebase complete maxillary denture	$220	D5710
Rebase complete mandibular denture	$211	D5711
Rebase maxillary partial denture	$208	D5720
Rebase mandibular partial denture	$208	D5721
Denture Reline Procedure		
Reline complete maxillary denture (chairside)	$124	D5730

Quality Care Dental Plan - Schedule of Benefits

Reline complete mandibular denture (chairside)	$124	D5731
Reline maxillary partial denture (chairside)	$114	D5740
Reline mandibular partial denture (chairside)	$114	D5741
Reline complete maxillary denture (laboratory)	$166	D5750
Reline complete mandibular denture (laboratory)	$166	D5751
Reline maxillary partial denture (laboratory)	$164	D5760
Reline mandibular partial denture (laboratory)	$164	D5761
Prosthodontics (continued)	**Maximum Benefit**	**Code**
Fixed Partial Denture Pontics		
(Each retainer and each pontic constitutes a unit in a fixed partial denture)		
Pontic-Cast high noble metal	$441	D6210
Pontic-Cast predominantly base metal	$414	D6211
Pontic-Cast noble metal	$430	D6212
Pontic-Porcelain fused to high noble metal	$436	D6240
Pontic-Porcelain fused to predominantly base metal	$402	D6241
Pontic-Porcelain fused to noble metal	$425	D6242
Pontic-Resin with high noble metal	$430	D6250
Pontic-Resin with predominantly base metal	$397	D6251
Pontic-Resin with noble metal	$410	D6252
Fixed Partial Denture Retainers - Crowns		
Crown-Resin with high noble metal	$486	D6720
Crown-Resin with predominartly base metal	$461	D6721
Crown-Resin with noble metal	$469	D6722
Crown-Porcelain fused to high noble metal	$497	D6750
Crown-Porcelain fused to predominantly base metals	$464	D6751
Crown-Porcelain fused to noble metal	$475	D6752
Crown-3/4 cast high noble metal	$469	D6780
Crown-Full cast high noble metal	$480	D6790
Crown-Full cast predominantly base metal	$455	D6791
Crown-Full cast noble metal	$472	D6792
Other Fixed Partial Denture Services		
Recement Fixed Partial Denture	$ 58	D6930
Fixed Partial Denture Repair, by report	$ 49	D6980
Oral Surgery	**Maximum Benefit**	**Code**
Extractions		
Coronal Remnants - Deciduous Tooth	$ 75	D7111
Extraction, Erupted Tooth or Exposed Root (elevation or forceps removal)	$ 70	D7140
Surgical Extraction		
(Includes local anesthesia, suturing if needed, and routine postoperative care)		
Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth	$109	D7210
Removal of impacted tooth - soft tissue	$136	D7220
Removal of impacted tooth - partially bony	$181	D7230
Removal of impacted tooth - completely bony	$213	D7240
Removal of impacted tooth - completely bony with unusual surgical complications	$267	D7241
Surgical removal of residual tooth roots (cutting procedure)	$115	D7250
Other Surgical Procedures		
Biopsy of oral tissue - hard (bone/tooth)	$453	D7285
Biopsy of soft tissue - soft (all others)	$186	D7286
Alveoloplasty in conjunction with extractions, per quadrant	$127	D7310
Alveoloplasty not in conjunction with extractions, per quadrant	$565	D7320
Frenulectomy - separate procedure	$266	D7960
Adjunctive General Services	**Maximum Benefit**	**Code**
Surgical Incision		
Palliative (emergency) treatment of dental pain (minor procedure)	$ 55	D9110
Anesthesia **General Anesthesia and Intravenous Sedation will be covered only if a qualified medical condition exists with supporting documentation from the patient's medical provider.**		
General anesthesia - first 30 minutes	$222	D9220
General anesthesia - each additional 15 minutes	$ 93	D9221
Intravenous sedation/analgesia - first 30 minutes	$180	D9241
Intravenous sedation/analgesia - each additional 15 minutes	$ 75	D9242
Miscellaneous Services		
Occlusal guards, by report	$146	D9940
Occlusal adjustment, limited	$ 70	D9951
Occlusal adjustment, complete	$396	D9952

Who to call for information...Plan Administrators

Healthcare Plan Name/Administrator	Toll-Free Telephone Number	TDD / TTY Number	Web Site Address
Health Alliance HMO	(800) 851-3379	(217) 337-8137	www.healthalliance.org
Health Alliance Illinois	(800) 851-3379	(217) 337-8137	www.healthalliance.org
HealthLink OAP	(800) 624-2356	(800) 624-2356, ext 6280	www.healthlink.com
HMO Illinois	(800) 868-9520	(800) 888-7114	www.bcbsil.com/stateofillinois
OSF Health Plans	(888) 716-9138	(888) 817-0139	www.osfhealthplans.com
OSF Winnebago	(888) 716-9138	(888) 817-0139	www.osfhealthplans.com
PersonalCare	(800) 431-1211	(217) 366-5551	www.personalcare.org
Unicare HMO	(888) 234-8855	(312) 234-7770	www.unicare.com

Plan Component	Contact For:	Administrator's Name and Address	Customer Service Phone Numbers and Web Site Address
Vision Plan Administrator	Vision services, benefits, network providers, claim forms and filing.	**Vision Service Plan (VSP)** Plan 222 P.O. Box 997105 Sacramento, CA 95899-7105	(800) 877-7195 (800) 428-4833 (TDD/TTY) www.vsp.com
Life Insurance Plan Administrator	Life insurance coverage and claim information.	**Minnesota Life Insurance Company** 1 North Old State Capitol, Suite 305 Springfield, IL 62701	(888) 202-5525 (800) 526-0844 (TDD/TTY)
Long-Term Care (LTC) Insurance	Long-term care insurance coverage.	**MetLife** (no address required)	(800) 438-6388 (800) 638-1004 (TDD/TTY)
Deferred Compensation Program	Long-term supplemental retirement savings program. Provides investment opportunities with payroll deducted, pre-tax dollars.	**CMS Deferred Compensation Division** 201 East Madison Street P.O. Box 19208 Springfield, IL 62794-9208	(800) 442-1300 (800) 526-0844 (TDD/TTY) www.state.il.us/cms/employee/defcom
FSA Plan Administrator	Information on MCAP/DCAP and claim eligibity.	**Fringe Benefits Management Company** P.O. Box 1800 Tallahassee, FL 32302-1800	(800) 342-8017 (800) 955-8771 (TDD/TTY) (850) 514-5817 (fax) www.fbmc-benefits.com
Qualified Transportation Benefit (QTB) Program	Information on setting aside pre-tax dollars for transportation and parking expenses.	**WageWorks** 2 Waters Park Drive, Suite 250 San Mateo, CA 94403	(877) 924-3967 (800) 526-0844 (TDD/TTY) www.wageworks.com
Health/Dental Plans, Medicare COB Unit, FSA Unit, COBRA Unit, Life Insurance, Adoption and Smoking Cessation Benefits	General information on the state health plans or other benefits.	**CMS Group Insurance Division** 201 East Madison Street P.O. Box 19208 Springfield, IL 62794-9208	(217) 782-2548 (800) 442-1300 (800) 526-0844 (TDD/TTY) www.benefitschoice.il.gov

Who to call for information...Plan Administrators

Plan Component	Contact For:	Administrator's Name and Address	Customer Service Phone Numbers
Quality Care Health Plan (QCHP) Medical Plan Administrator	Medical service information, network providers, claim forms, ID cards, claim filing/resolution, and pre-determination of benefits.	**CIGNA** Group Number 3181456 CIGNA HealthCare P.O. Box 5200 Scranton, PA 18505-5200	(800) 962-0051 (nationwide) (800) 526-0844 (TDD/TTY) http://provider.healthcare.cigna.com/soi.html
QCHP Notification and Medical Case Management Administrator	Notification prior to hospital services. Non-compliance penalty of $800 applies.	**Intracorp, Inc.** (no address required)	(800) 962-0051 (nationwide) (800) 526-0844 (TDD/TTY) http://provider.healthcare.cigna.com/soi.html
QCHP Prescription Drug Plan Administrator	Information on prescription drug coverage, pharmacy network, mail order, specialty pharmacy, ID cards and claim filing.	**Caremark, Inc.** Group Number 1400 **Paper Claims:** P.O. Box 686005 San Antonio, TX 78268-6005 **Mail Order Prescriptions:** P.O. Box 7624 Mt. Prospect, IL 60056-7624	(866) 212-4751 (nationwide) (800) 231-4403 (TDD/TTY) www.caremark.com
QCHP Behavioral Health Administrator	Mental Health and Substance Abuse notification, authorization, claim forms and claim filing/resolution.	**Magellan Behavioral Health** Group Number 3181456 P.O. Box 2216 Maryland Heights, MO 63043	(800) 513-2611 (nationwide) (800) 526-0844 (TDD/TTY) www.MagellanHealth.com
Employee Assistance Program (EAP)	Confidential assistance and assessment services, ID cards.	**Magellan Behavioral Health** (no address required)	(866) 659-3848 (nationwide) (800) 526-0844 (TDD/TTY) www.MagellanHealth.com
Quality Care Dental Plan (QCDP) Administrator	Dental services, claim filing, ID cards.	**CompBenefits** Group Number 950 P.O. Box 4677 Chicago, IL 60680-4677	(800) 999-1669 (312) 829-1298 (TDD/TTY) www.compbenefits.com

BENEFIT CHOICE ELECTION FORM – PERIOD 2

July 26 – August 20, 2004 (Changes effective September 1, 2004)

COMPLETE THIS FORM ONLY TO MAKE A CHANGE IN YOUR BENEFITS

SECTION A: EMPLOYEE INFORMATION (required)

Social Security Number	Last Name	First Name	Phone Numbers
- -			Home:
			Work:

SECTION B: OPT OUT / OPT IN

OPT OUT/OPT IN of Health & Dental		
☐ Opt Out	☐ Opt In	**See Section B instructions on the instruction sheet for requirements.**

SECTION C: HEALTH PLAN ELECTIONS (complete only if changing your health)

Health Plan Election *		
Quality Care Health Plan (QCHP) ☐		
Managed Care: ☐ HMO or ☐ OAP		**If Managed Care is selected you must provide the physician's 6-digit Primary Care Provider (PCP) number.**
Carrier Code _____ (2 alpha characters)	PCP# _____ (6 numeric digits)	Plan Name _____

* You must complete a Coordination of Benefits Worksheet for yourself and/or any dependent who has other insurance coverage (including Medicare or Medicaid). The Coordination of Benefits Worksheet is available at www.benefitschoice.il.gov.

SECTION D: DENTAL PLAN OPTION (complete only if electing not to participate in the dental plan)

Dental Plan Option
I choose not to participate in the dental plan ☐

SECTION E: OPTIONAL LIFE INSURANCE (complete this section only if changing life coverage elections)

OPTIONAL LIFE	☐ INCREASE	☐ DECREASE	☐ CANCEL	AD&D	
☐ 1 x Basic	☐ 3 x Basic	☐ 5 x Basic	☐ 7 x Basic	☐ CANCEL AD&D	☐ BASIC only (Basic)
☐ 2 x Basic	☐ 4 x Basic	☐ 6 x Basic	☐ 8 x Basic		☐ COMBINED (Basic + Optional Life)

SECTION F: DEPENDENT INFORMATION [1] (dependent must be enrolled in the same plans as the member)

HEALTH			**LIFE [2]** ($10,000)		Name	SSN	Birth Date	Relationship [3]	**PCP #** (6 digits)
Add	Drop	Change	Add	Drop					
☐	☐	☐	☐	☐					
☐	☐	☐	☐	☐					
☐	☐	☐	☐	☐					
☐	☐	☐	☐	☐					

Notes: [1] Documentation required to add dependents – see the instruction sheet for specific documentation requirements.

[2] Statement of Health form required when adding Spouse or Child Life (form available at www.benefitschoice.il.gov).

[3] Relationship must be spouse, son, daughter, stepchild, adopted child, adjudicated child or legal guardian.

I authorize prevailing premiums to be deducted from my pay or annuity for those plans I have selected. This authorization will remain in effect until I provide written notice to the contrary. The information contained in this form is complete and true. I agree to abide by all Group Insurance Program rules. I agree to furnish additional information requested for enrollment or administration of the plan I have elected.

MEMBER SIGNATURE: _____ DATE: _____

GIR/GIP SIGNATURE: _____ DATE: _____

Give completed form to your GIR in your Benefits Office by August 20, 2004.

BENEFIT CHOICE ELECTION FORM
INSTRUCTION SHEET

If you are keeping your current coverage elections, you do not need to complete the Benefit Choice Election Form.

SECTION A – EMPLOYEE INFORMATION (Complete all fields)

SECTION B – OPT OUT / OPT IN

If you wish to opt out of, or opt into, the State's Group Insurance coverage you must complete the 'Opt Out/Opt In' portion of Section B and submit an 'Opt Out/Opt In Election Certificate' (CMS-500 - form available at www.benefitschoice.il.gov or through your agency Group Insurance Representative). If you elect to opt out, you must also provide proof of comprehensive major medical health coverage (indemnity or managed care) provided by an entity other than the Department of Central Management Services. Proof of coverage may be a certificate of creditable coverage or a copy of the front and back of your health ID card.

SECTION C – HEALTH PLAN ELECTIONS

Do not complete this section if you only want to change your Primary Care Physician (PCP) – you must contact your carrier directly in order to make this change.

If you wish to change your health plan, you must check either the Quality Care Health Plan (QCHP) or one of the managed care plan boxes (HMO or OAP). If electing/changing managed care plans, you must enter the managed care plan's two-digit carrier code (see page 11 of the FY2005 Benefit Choice brochure for carrier codes), the plan's name, and the 6-digit PCP number. The 6-digit PCP number may be found in the managed care plan provider directory or the individual plan's online website (see pages 19 and 20 of the FY2005 Benefit Choice brochure for the Plan Administrator contact information).

SECTION D – DENTAL PLAN OPTION

If you wish to drop your dental coverage, you must check the 'I choose not to participate in the dental plan' box (proof of other dental coverage is not required). If you waive dental coverage, you can re-enroll only during the annual Benefit Choice election period or upon opting back into the health program.

SECTION E – OPTIONAL LIFE INSURANCE

Complete this section if you wish to add/drop/increase or decrease either your Optional Life[1] or Accidental Death and Dismemberment coverage. Note: Optional Life Coverage subject to $3,000,000 maximum (basic + optional life). AD&D maximum is 5 times the employee salary (basic plus 4 times optional coverage).

SECTION F – DEPENDENT INFORMATION

Complete this section if you are adding, dropping or changing your dependent health or life[1] coverage. If you are adding health or life dependent coverage, you must provide the appropriate documentation as indicated below:

Spouse	Marriage certificate
Natural Child through Age 18	Birth certificate
Stepchild	Birth certificate, marriage certificate indicating your spouse is the child's parent, and proof the child resides with you at least 50% of the time.
Adopted Child	Adoption certificate stamped by the circuit clerk.
Adjudicated Child/Legal Guardian	Court documentation signed by a judge.
Student	Birth certificate, Dependent Coverage Certification Statement (CMS-138)**, and verification of full-time student enrollment in an accredited school.
Handicapped	Birth certificate, Dependent Coverage Certification Statement (CMS-138)**, and a letter from the doctor 1) detailing the dependent's limitations, capabilities and onset of condition from a cause originating prior to age 19, 2) a diagnosis from a physician with an ICD-9 diagnosis code, and 3) a statement from the Social Security Administration with the Social Security disability determination.
** The Dependent Coverage Certification Statement (CMS-138) is available online at www.benefitschoice.il.gov or through your agency Group Insurance Representative (GIR).	

[1] If you are applying to add or increase Optional Life, Spouse Life or Child Life, you must complete, sign and mail a Statement of Health application to ***Minnesota Life, 1 North Old Capitol Plaza, Suite 305, Springfield, IL 62701***. The Statement of Health application is available at www.benefitschoice.il.gov or through your agency GIR.
Please note: Child life will be automatically increased to $10,000 effective 7/1/04. Spouse life will be automatically increased to $10,000 effective 7/1/04 for active employees and immediate annuitants under the age of 60.

SIGNATURE

You must sign and date the Benefit Choice Election Form and give to your agency GIR by August 20, 2004 in order for your elections to be effective September 1, 2004. Dependent documentation must be submitted to your GIR within 10 days of the end of the Benefit Choice Period. If documentation is not provided within the 10 days your dependents will not be added.

Illinois Department of Central Management Services
Bureau of Benefits
PO Box 19208
Springfield, IL 62794-9208

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